

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

173321										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17332																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
Rose										R. Baseman										Dec. 19, 1968 9:30 PM																													
3. SEX Female										4. RACE White										5. DATE OF BIRTH Sept. 6, 1885										6. AGE (In years lost birthday) 83 YRS.										IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Carroll Co., Md.																			
10. CITY OR TOWN OF DEATH Manchester										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Longview Nursing Home										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Owings Mills										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 223 Gwynnbrook Ave.									
14. FATHER'S NAME John										15. MOTHER'S MAIDEN NAME Yox Margaret Fredrick										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. 212-48-5119										17. INFORMANT 1929 Whistler Avenue, Baltimore, Maryland 21230									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Arteriosclerotic Cardiovascular Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 7-25, 1968, to 12-19, 1968, that (I) (we) last saw the deceased alive on 12-18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Joseph E. Bush M.D.										22c. DATE SIGNED 12-19-68										22d. PHYSICIAN'S NAME (Type) Joseph E. Bush M.D.										22e. ADDRESS Hampstead, Maryland.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Dec. 23, 1968										23c. NAME OF CEMETERY OR CREMATORY Holy Family Church Cem.										23d. LOCATION (City or Town) (County) (State) Harrisonville, Balto. Md.																			
24. FUNERAL DIRECTOR H. J. Schmitt										ADDRESS Owings Mills, Md.										25a. REC'D BY REGISTRAR DEC 23 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																			

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RECEIVED

11332

James H. H. H.
James H. H. H.

X

[Large signature]

DEC 11 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

17322										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17333																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
CLARENCE RUSSELL BELL										Month 12 Day 2 Year 68										27 M																													
3. SEX MALE										4. RACE WHITE										5. DATE OF BIRTH APRIL 17, 1901										6. AGE (In years last birthday) 67 YRS.																			
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH CARROLL Co.																			
10. CITY OR TOWN OF DEATH WESTMINSTER										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL Co GEN. HOSP										12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) CLERK, COUNTY ROADS DEPT.										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.										13b. COUNTY CARROLL										13c. CITY OR TOWN WESTMINSTER										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 25 WESTMORELAND ST									
14. FATHER'S NAME First Middle Last EDWIN D. BELL SR.										15. MOTHER'S MAIDEN NAME First Middle Last BARBARA EICHORN										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO										16b. SOCIAL SECURITY NO. 213-01-9180-A										17. INFORMANT EDWIN D. BELL, JR., ADDRESS SAME									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 DUE TO, OR AS A CONSEQUENCE OF (b) WITH EXTENSIVE INVOLVEMENT OF BOTH LUNGS DUE TO, OR AS A CONSEQUENCE OF (c) LUNGS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1621																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 12/1, 1968, to 12/2, 1968, that (I) (we) lost saw the deceased alive on 12/2/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE [Signature] MD										22c. DATE SIGNED 12/2/68										22d. PHYSICIAN'S NAME (Type) [Signature]																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 12/5/68										23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEMETERY WESTMINSTER MD.										23d. LOCATION (City or Town) (County) (State)																			
24. FUNERAL DIRECTOR [Signature]										25a. REC'D BY REGISTRAR DEC 6 1968										25b. REGISTRAR'S SIGNATURE [Signature]																													

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VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17323									
17334									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR Min	
John Crogen Bennett						Dec. 11 1968		1:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Aug. 16, 1896		72 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Co.,		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll Co. Gen. Hosp.		Buyer - Western Elect. Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Carroll		Westminster				166 David Ave.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Oliver Bennett			Naomi Crogen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		WWI & WWII		215-10-4064		Dorothy Bennett 166 David Ave. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurysm</u> 4419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 022X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 11, 1968</u> , to <u>Dec. 11, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John S. Harshey, MD</u>				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/11/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY MD</u>				22e. ADDRESS <u>8 Archer St. Westminster Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Dec. 11, 1968		Druid Ridge Cemetery		Pikesville, Balto., Md.			
24. FUNERAL DIRECTOR <u>H. J. Ellhardt</u>				ADDRESS <u>Owings Mills, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A 374
30M REV. 1-68

17324										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17335																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First ANNA										Middle P.										Last BOHRER										Month Dec. 5, 1968										Day 8 P.M.																			
3. SEX Female										4. RACE White										5. DATE OF BIRTH May 19, 1891										6. AGE (In years last birthday) 77 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Carroll Md.																													
10. CITY OR TOWN OF DEATH Mt. Airy										11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) Box 325										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Telephone Operator										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland										13b. COUNTY Carroll										13c. CITY OR TOWN Mt. Airy										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER Box 325																			
14. FATHER'S NAME First William Middle T. Last Harry										15. MOTHER'S MAIDEN NAME First Mary Middle Ann Last Boone																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 216-05-8827										17. INFORMANT Address Miss Sheila Bohrer Same As #13																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Anteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thromboses DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years - 2 weeks -																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (the hospital) attended the deceased from 10/20, 1963, to 12/5, 1968, that (I) (we) last saw the deceased alive on 12/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																																																											
22b. SIGNATURE James P. Kerr M.D.										DEGREE ATTENDING PHYS.										<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.										22c. DATE SIGNED 12/6/68																													
22d. PHYSICIAN'S NAME (Type) Dr. James P. Kerr										22e. ADDRESS Damascus, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 12/9/1968										23c. NAME OF CEMETERY OR CREMATORY Damascus Cemetery										23d. LOCATION (City or Town) (County) (State) Damascus, Montgomery, Md.																													
24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.										25a. REC'D BY REGISTRAR DATE DEC 10 1968										25b. REGISTRAR'S SIGNATURE f Charles Judge																																							

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VR A15 (4)
30M REV. 11-68

17325										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17336																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
ROSELLA SAYLOR BOND										Dec. 13 1968										5P M																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																													
FEMALE										WHITE										12/9/1879										89 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
MARYLAND										U.S.																				CARROLL																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
RURAL, NEW WINDSOR										BOARDING HOME										HOUSEWIFE										AT HOME																																																	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																																							
MARYLAND										FREDERICK										JOHNSVILLE										YES										NO										RURAL UNION BRIDGE MD																													
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
JOHN H. SAYLOR										SARAH DIEHL										No										218-32-3143										ROY G. BOND										UNION BRIDGE, MD										RURAL MD																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
4129																				Arteriosclerotic CVD																				years																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)										DUE TO, OR AS A CONSEQUENCE OF										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										4221																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from 3/27/68, 19, to 12/13/68, 19, that (I) (we) lost saw the deceased alive on 12/12/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE M. E. Robertson MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12/13/68																																																											
22d. PHYSICIAN'S NAME (Type) M. E. ROBERTSON										22e. ADDRESS New Windsor, Md																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 12/16/1968										23c. NAME OF CEMETERY OR CREMATORY BEAVER DAM CEM.										23d. LOCATION (City or Town) (County) (State) FREDERICK COUNTY, MD																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
W. H. Hutzler										UNION BRIDGE, MD										DATE DEC 17 1968										J. Charles Judge																																																	

1. The first of the series of the
2. The second of the series of the
3. The third of the series of the
4. The fourth of the series of the
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

17326				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17337			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Francis Asbury Boston Jr.				2a. DATE OF DEATH Month Day Year 12-20-68				2b. HOUR Minute 7:00 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 01-10-95		6. AGE (In years lost birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Brakeman		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 844 W. 37th St.			
14. FATHER'S NAME First Middle Last Francis A. Boston				15. MOTHER'S MAIDEN NAME First Middle Last Anna Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 717-07-8164		17. INFORMANT Address Records, Springfield State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Bronchopneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12-17- , 19 68 , to 12-20 , 19 68 , that (I) (we) last saw the deceased alive on 12-20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Paul G. Ensor</i>				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. DATE SIGNED 12-20-68											
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D.				22e. ADDRESS Springfield State Hospital, Sykesville							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/23/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) Baltimore		(County)		(State)	
24. FUNERAL DIRECTOR <i>Paul E. [unclear]</i>				ADDRESS 3615 Chestnut Ave		25a. REC'D BY REGISTRAR DATE DEC 23 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR				
RUSSELL		EDWARD	BOYER	DECEMBER 5, 1968		3:35 A					
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
Male	White		5-11-10		58 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Pennsylvania		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Sykesville		Springfield State Hospital		Odd Jobs							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Baltimore City		Baltimore				No fixed address			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Ralph		Boyer	Katie	Dundore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				Unknown		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>6-24-68</u> , 19____, to <u>12-5-68</u> , 19____, that (I) (we) last saw the deceased alive on <u>12-5-68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
<u>Octavio A. Ruiz M.D.</u>									12-5-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Octavio A. Ruiz, M. D.		Springfield State Hospital Sykesville, Md. 21784									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
<u>General</u>		<u>Dec. 9, 1968</u>		<u>St. Mary's Cemetery</u>		<u>Sykesville</u>					
24. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. DATE					
<u>Frank J. Newell</u>		<u>DEC 16 1968</u>		<u>Charles Judge</u>							

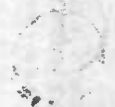
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17339

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M			
KATIE GLADYS BREHM					DEC 23 1968		2 00			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE	WHITE		APRIL 16 1899		69 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
CARROLL, MD		USA.				CARROLL				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
RFD WESTMINSTER		ROUTE #4		PRACTICAL NURSE		HOSPITAL				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND		CARROLL		WESTMINSTER				ROUTE #4		
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last								
JOHN J. BREHM		EMMA LEISTER.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO				214-071645		LELA BREHM		SISTER ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X BRONCHOPNEUMONIA								6 DAYS		
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA BREAST								8 YEARS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
170X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from DEC 1958 to DEC 1968, that (I) (we) last saw the deceased alive on DEC 23 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Daniel I. Welliver M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-22-68.			
22d. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER M.D.					22e. ADDRESS WESTMINSTER MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12/26/68		Leister Cemetery		Westminster, MD #4, Md.				
24. FUNERAL DIRECTOR J. E. Myers Jr., Westminster, Md.					25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



NO

JOHN J. BRENN

EMMA FEISTEN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) John ^{First} Ellsworth ^{Middle} Brockman ^{Last}			2a. DATE OF DEATH 12 ^{Month} 10 ^{Day} 68 ^{Year}		2b. HOUR 9 P.M.			
3. SEX Male	4. RACE White		5. DATE OF BIRTH 3-30-1910		6. AGE (In years last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH V. B. Carroll		
10. CITY OR TOWN OF DEATH Sykesville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2720 Jefferson St.
14. FATHER'S NAME George W. Brockman			15. MOTHER'S MAIDEN NAME Louise M. Pitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Louise M. Brockman Mother 2720 Jefferson St. Balto. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours minutes								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 Epilepsy								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 7-24-1959, to 12-10-1968, that (I) (we) last saw the deceased alive on 12-10-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Gracito V. Patricio				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/10/68		
22d. PHYSICIAN'S NAME (Type) Gracito V. Patricio M.D.				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/13/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MARYLAND				25a. REC'D BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

17374

UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Brown Irene Pauline Brown						2a. DATE OF DEATH Month Day Year 12 5 68			2b. HOUR 11:30 P M		
3. SEX female		4. RACE negro		5. DATE OF BIRTH 3-22-81		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) cook				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2115 Walbrook Ave.			
14. FATHER'S NAME First Middle Last Elma Cross				15. MOTHER'S MAIDEN NAME First Middle Last Mary Marshall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 212-22-0238		17. INFORMANT Address Hospital Records - Springfield Hosp.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CBS assoc. with cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) CBS assoc. with cerebral arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 334x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11-18 , 19 68 , to 12-5 , 19 68 , that (I) (we) lost the deceased alive on 12-5 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul G. Easor						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5 Dec 68			
22d. PHYSICIAN'S NAME (Type) Paul G. Easor M.D.						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-10-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR V.R. Bailey						25a. REC'D BY REGISTRAR DEC 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			
Kelson Funeral Home 1348 Calhoun St.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17331

CERTIFICATE OF DEATH

17342

1. DECEASED-NAME (Type or print) PHILOMENA CLEMENTINE BRYTE			2a. DATE OF DEATH Month 12 Day 19 Year 68			2b. HOUR 8¹⁰ M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 23, 1919		6. AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO. Md.				
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4 OAK AVE.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE-WIFE			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4 OAK AVE.	
14. FATHER'S NAME First Middle Last STANISLAUS J. LEWANDOWSKI			15. MOTHER'S MAIDEN NAME First Middle Last KLEMENTYNA ZAMBRZKA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES 43545			16b. SOCIAL SECURITY NO. 212-16-9977		17. INFORMANT WAYNE H. BRYTE,			Address SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CORONARY HEART DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1963 , to 12/19, 1968 , that (I) (we) last saw the deceased alive on 12/18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Vincent J. Fiocco Jr. MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/19/68		
22d. PHYSICIAN'S NAME (Type) VINCENT J. FIOCCO JR.						22e. ADDRESS ANCHOR ST. WESTMINSTER, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12/23/68		23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE MD		
24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.						25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

17342

CHARLES H. WATKINS

1901

PAULINE L. WATKINS

WHITE 1901

BRIDGE ST. 2.0

WESTMINSTER 2 CAR WIFE
HAROLD T. CARROLL WESTMINSTER
HAROLD

STANLEY J. WESTMINSTER
HAROLD 2150-111 HAYNE H. PRYDE
HAROLD 2150-111 HAYNE H. PRYDE

VICTIM J. FORD JR
FORD 12/5/68 NATIONAL CEMENT, BIRMINGHAM
FORD 12/5/68 NATIONAL CEMENT, BIRMINGHAM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

17343

1. DECEASED-NAME (Type or print) Evelyn Virgie Pollard Burdette			2a. DATE OF DEATH Month Day Year 12-23-68			2b. HOUR 1:45 P M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7-11-1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll			Md.		
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield St. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Laytonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 1002		
14. FATHER'S NAME First Middle Last Frank Pollard			15. MOTHER'S MAIDEN NAME First Middle Last Allie UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. 579-40-3321		17. INFORMANT Springfield St. Hospital				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 337X (b) (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11-29-68, 19__, to 12-23-68 19__, that (I) (we) lost saw the deceased alive on 12-23-68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul G. Ensor, M.D.				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-23-68			
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D.				22e. ADDRESS Springfield St. Hosp. Sykesville, Md.							
23a. BURIAL, CREMATION, ETC. (Specify)		23b. DATE Dec. 27 1968		23c. NAME OF CEMETERY OR CREMATORY Laytonsville St. Pauls		23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md					
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville Md		25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH December 17, 1968			2b. HOUR 1:15 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6-30-04		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3530 Lynchester Road	
14. FATHER'S NAME First Middle Last Samuel Burry		15. MOTHER'S MAIDEN NAME First Middle Last Marie Schwartz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>450X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>465X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-10-</u> , 19 <u>68</u> to <u>12-17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Octavio A. Ruiz</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-17-68			
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22e. ADDRESS Sykesville, Maryland 21784 Springfield State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/20/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 19 1968		REGISTRAR'S SIGNATURE <u>John A. Jones</u>			

Page 1 12/10/68
United States of America, District of Columbia

DEC 19 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17334

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17345

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Julia Madeline Carey			2a. DATE OF DEATH 12 Month 10 Day 68 Year			2b. HOUR 1:40 PM			
3. SEX female		4. RACE white		5. DATE OF BIRTH 8/30/87		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Rural--Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) millinery		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6805 Brennan Lane	
14. FATHER'S NAME First Patrick Middle - Last Holmes			15. MOTHER'S MAIDEN NAME First Katie Middle - Last Sheridan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-16-5055		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Pyelonephritis, right kidney								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Years Days - weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from 3/21/1968 , to 12/10/1968 , that he (we) lost saw the deceased alive on 12/10/1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. he (we) (did) not view the body after death.									
22b. SIGNATURE Renato R. Espina				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/10/68			
22d. PHYSICIAN'S NAME (Type) Renato R. Espina, M. D.				22e. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-13-68		23c. NAME OF CEMETERY OR CREMATORY State of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Md			
24. FUNERAL DIRECTOR Francis Collins		ADDRESS 500 University Blvd W Silver Spring, Md		25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR	
Mabel L. Chamberlin						Month 12 Day 28 Year 68			12 ¹⁰ M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		May 7, 1887		81 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Va.		USA				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll Co. Hospt.			Housewife				
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Carroll		Westminster				114 Washington Rd.	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
First Middle Last					First Middle Last					
William Chamberlin					Margaret Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, give war or dates of service			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			215-14-1172A		Mrs. Hellen Siegman Westminister, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC CORONARY HEART DISEASE</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27, 1968</u> , to <u>12/28, 1968</u> , that (I) (we) lost saw the deceased alive on <u>12/28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
<u>Wincent J. Kucera MD</u>					12/28/68					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Dec. 31, 1968		Mt. Hebron Cemetery		Winchester, Va.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tipton - Eline Funeral Home Hampstead, Md.					DATE DEC 31 1968		<u>Charles Judge</u>			

1. Description of the property

2. Date of acquisition

3. Name of the donor

4. Name of the recipient

5. Name of the organization

6. Name of the individual

7. Name of the institution

8. Name of the project

9. Name of the sponsor

10. Name of the committee

11. Name of the board

12. Name of the council

13. Name of the association

14. Name of the society

15. Name of the club

16. Name of the league

17. Name of the union

18. Name of the confederation

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1/68

17336										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17347																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First John Middle Christ III. Last										Month Dec. Day 9, Year 1968										1:40A.M.																													
3. SEX Male										4. RACE White										5. DATE OF BIRTH JAN. 27, 1910										6. AGE (In years last birthday) 58 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) N. J.										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH CARROLL Md.																			
10. CITY OR TOWN OF DEATH Finksburg										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Louisville Rt 32										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foreman										12b. KIND OF BUSINESS OR INDUSTRY Rental CAR																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY CARROLL										13c. CITY OR TOWN Finksburg										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER Route 32									
14. FATHER'S NAME First John Middle Christ II. Last										15. MOTHER'S MAIDEN NAME First Unknown Middle Last																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes										(If yes give war or dates of service) WWII										16b. SOCIAL SECURITY NO. 141-07-6764										17. INFORMANT Mr Palmer Miller										Address Finksburg, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185X PNEUMONIA - TERMINAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 3-4 mos.																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 177X																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 22, 1968, to Dec. 9, 1968, that (I) (we) last saw the deceased alive on 12/8/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Martin E. Strobel										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12/9/68																													
22d. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL										22e. ADDRESS REISTERSTOWN, MD.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 12-12-68										23c. NAME OF CEMETERY OR CREMATORY Lakewood Cemetery										23d. LOCATION (City or Town) Sykesville (County) Md. (State)																			
24. FUNERAL DIRECTOR Harry W. Haight										ADDRESS Sykesville, Md.										25a. REC'D BY REGISTRAR DEC 12 1968										25b. REGISTRAR'S SIGNATURE J. Charles Judge																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First S. Middle (Clairborne) Last (Clairborne)			2a. DATE OF DEATH Month Day Year		2b. HOUR	
William (Type or print)						December 10, 1968		4:25 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Male		N negro		10-16-96		72 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Virginia		USA				Carroll			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield St. Hospital		Dishwasher					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Balto. City		Baltimore				1016 Arlington Avenue	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
H enderson Clairborne				Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Unknown		213-07-4220		Springfield St. Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									Years
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4129</u>									Years
(b) <u>Generalized arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>4221</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-14-68</u> , 19__, to <u>12-10-68</u> , 19__, that (I) (we) last saw the deceased alive on <u>12-10-68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Glocrito G. Sagisi</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
						12-10-68			
22d. PHYSICIAN'S NAME (Type) <u>Glocrito G. Sagisi</u>				22e. ADDRESS <u>Springfield St. Hospital Sykes, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/13/68		Arbutus Mem. Park		Arbutus, Maryland			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Charles A. Rice 661 W. Barre St.				DEC 12 1968		<u>Glocrito G. Sagisi</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304M REV. 1-68

17338		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17349	
1. DECEASED-NAME (Type or print) First Middle Last John Harman Clark			2a. DATE OF DEATH Month Day Year Dec 20 1968			2b. HOUR 11:30 M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH May 19, 1887		6. AGE (In years (last birthday) YRS. MONTHS DAYS 81	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Co., Md.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll County Gen.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Local Haul	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 65 Featherbed Lane		14. FATHER'S NAME First Middle Last William Henry Clark		15. MOTHER'S MAIDEN NAME First Middle Last Rachel Blake		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	
16b. SOCIAL SECURITY NO. 216-03-1820		17. INFORMANT Mrs. Viola Flemming Reister		Address Rt. #3 Box 2		Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 13, 1968</u> , to <u>Dec 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John S. Harshey, MD</u>		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/20/68	
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, MD		22e. ADDRESS 8 Anchor St. Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Owings Mills, Balto. Md.	
24. FUNERAL DIRECTOR <u>H. J. Schhardt</u>		ADDRESS Owings Mills, Md.		25a. RECEIVED BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17329 CERTIFICATE OF DEATH 17350									
1. DECEASED-NAME (Type or print) First Middle Last Grace J. Dell					2a. DATE OF DEATH Month Day Year Dec. 16 1968			2b. HOUR M 1:30	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 5, 1902		6. AGE (In years lost birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Hospt.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 1	
14. FATHER'S NAME First Middle Last James Abbott			15. MOTHER'S MAIDEN NAME First Middle Last Garafiela Hare						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-44-1137		17. INFORMANT Address Woodrow Dell Rt. 1 Finksburg (Son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION 4/20/1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 14, 1968 , to Dec 16, 1968 , that (I) (we) last saw the deceased alive on Dec 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John S. Harshey					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/16/68		
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.					22e. ADDRESS 8 Archer St. Westminster Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery		23d. LOCATION (City or Town) (County) (State) Hampstead Carroll Co. Md.			
24. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead, Md.					25a. REC'D BY REGISTRAR DATE DEC 20 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-7-66

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17340 CERTIFICATE OF DEATH 17351									
1. DECEASED-NAME (Type or print) GOTTFRIED			First Middle Last			2a. DATE OF DEATH Dec Month Day 11 Year 68			2b. HOUR 4P M
3. SEX M		4. RACE W		5. DATE OF BIRTH May 25, 1887			6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Switzerland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mineral Hill Rd. Sykesville			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist			12b. KIND OF BUSINESS OR INDUSTRY Duck Machine	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN SYKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER MINERAL HILL RD.	
14. FATHER'S NAME ZAK MARIAS			First Middle Last EGWI			15. MOTHER'S MAIDEN NAME First Middle Last unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown None			16b. SOCIAL SECURITY NO. 715-01-4297A		17. INFORMANT Mrs. Lucia Herwig, Mineral Hill Rd. Sykesville				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, metastatic, site, source</u> 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unknown</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1992 ASCVD, cardiomyopathy									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4 August, 1964, to Dec 11, 1968, that (I) (we) last saw the deceased alive on 5 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles H. Williams MD.				DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11 Dec 68	
22d. PHYSICIAN'S NAME (Type) Charles H. Williams M.D.				22e. ADDRESS P. Kesville, 41208, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Dec. 14, 1968		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.				25a. REC'D BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

11351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

173411				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17352			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Minnie Jane Elgen				2a. DATE OF DEATH 12 Month 13 Day 68 Year				2b. HOUR 2:55 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 13, 1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Manchester, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Longview Nursing Home, Inc. Home - wife		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 113 Liberty St.			
14. FATHER'S NAME First Middle Last Thomas Farrer				15. MOTHER'S MAIDEN NAME First Middle Last Rachel Richardson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no				16b. SOCIAL SECURITY NO. 220-46-4781		17. INFORMANT medial Houston 922 Russell Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Atherosclerotic Cardiovascular Disease & decompensation years DUE TO, OR AS A CONSEQUENCE OF (b) Coronary & Mitral Insufficiency years DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5-12, 1963, to 12-13, 1968, that (I) (we) last saw the deceased alive on 12-13-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William Speicher				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 12-13-68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Westminster Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/16/68		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery Westminster Carroll Md		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR J. E. Myers Jr.				ADDRESS Westminster, Md		25a. REC'D BY REGISTRAR DATE DEC 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

11382

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DEC 11 1968

17342

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Nellie Rebecca Ensor			2a. DATE OF DEATH December 27, 1968			2b. HOUR 6:45 M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7-13-91		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY Balto. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 704 Cator Avenue		
14. FATHER'S NAME Samuel L. Ensor			15. MOTHER'S MAIDEN NAME Eleanor Harmon			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 213-36-0533A	
17. INFORMANT Records, Springfield State Hospital			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) Mesenteric thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4227 (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CBS, associated with cerebral arteriosclerosis with psychotic reaction										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 8-22-1964 , to 12-27-1968 , that (I) (we) lost saw the deceased alive on 12-27-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Paul G. Ensor, M.D.				22c. DATE SIGNED 12-27-68		22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-30-68		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem		23d. LOCATION (City or Town) (County) (State) Pikesville Balto Co Md		23e. REGISTRAR'S SIGNATURE Charles Judge		
24. FUNERAL DIRECTOR Burgess Funeral Home Balto Md				25a. REC'D BY REGISTRAR DATE DEC 31 1968		25b. REGISTRAR'S SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in many cases, within 72 hours after death.

11353

RECORD OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17343

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17354

1. DECEASED-NAME (Type or print)			First LUCILLE	Middle (NMN)	Last EVERHART	2a. DATE OF DEATH Month Day Year DECEMBER 4, 1968			2b. HOUR 5:30 A		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 6-1-1889		6. AGE (in years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Baltimore City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4108 Fairview Ave.			
14. FATHER'S NAME First Middle Last Armstead Watkins			15. MOTHER'S MAIDEN NAME First Middle Last Leeanna Unk.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 108-26-9445		17. INFORMANT Address Records, Springfield State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4227</u> (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>12-11-66</u> , 19__, to <u>12-4-68</u> , 19__, that (I) (we) last saw the deceased alive on <u>12-4-68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Antonijs Glahn</u> DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-4-68				
22d. PHYSICIAN'S NAME (Type) Antonijs Glahn, M. D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/7/68		23c. NAME OF CEMETERY OR CREMATORY Carver Mem PK		23d. LOCATION (City or Town) Laurel		(County) Md.		(State)	
24. FUNERAL DIRECTOR <u>Earl Baltimore Funeral Home</u>					ADDRESS <u>1827 W. North Ave. Balt. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

17324

RECEIVED

17324

17324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17355									
1. DECEASED-NAME (Type or print) <i>Mollie</i>			First <i>S.</i> Middle <i>Eyler</i> Last			2a. DATE OF DEATH Month <i>Dec.</i> Day <i>22</i> Year <i>68</i>		2b. HOUR M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Jan. 3, 1892</i>		6. AGE (In years last birthday) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll Co.</i>		Md.	
10. CITY OR TOWN OF DEATH <i>Sykesville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Grand View Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Main Street</i>	
14. FATHER'S NAME First <i>Francis Glenn</i> Middle <i>Saffell</i> Last			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Orwings</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>217-09-6678</i>		17. INFORMANT <i>Mrs. Alice Christhill Orwings Mills, Md.</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Jarvis disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>few months</i> <i>5 yrs</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>4201 Influenza infection</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-1968</i> to <i>12-22-68</i> , that (I) (we) lost saw the deceased alive on <i>12-18-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James G. Saffell MD</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-24-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>James G. Saffell</i>				22e. ADDRESS <i>Reisterstown, Balto Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec. 24, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>All Saints</i>		23d. LOCATION (City or Town) (County) (State) <i>Reisterstown, Md.</i>			
24. FUNERAL DIRECTOR <i>J. F. Elme & Sons</i>				ADDRESS <i>Reisterstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

Handwritten notes and signatures, including names like "John" and "Mary", and dates like "1891".

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17345

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17356

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Arthur</u> First <u>Ferguson</u> Middle <u>Ferguson</u> Last			2a. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>68</u>			2b. HOUR <u>5:00 P</u>			
3. SEX <u>male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>4-14-07</u>		6. AGE (In years last birthday) <u>61</u> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 MRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u> Md.			
10. CITY OR TOWN OF DEATH <u>Sikesville Md</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>GAITHERSBURG</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>19 WALKER AVE</u>	
14. FATHER'S NAME First <u>ARTHUR</u> Middle <u>MMN</u> Last <u>FERGUSON</u>			15. MOTHER'S MAIDEN NAME First <u>SALLIE</u> Middle <u>-</u> Last <u>POWELL</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>-</u>			16b. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HISTORY RECORD SHEET.</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NATURAL CAUSES, CORONARY</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (PER DR. HAPNER'S NOTE) (b) <u>(Miles), R.N.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>TIME: 5pm</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <u>NONE</u>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> , 19 <u>55</u> , to <u>12-27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Isa E. Hapner</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12-27-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>ISAK, E. HAPNER</u>				22e. ADDRESS <u>SPRINGFIELD STATE HOSPITAL</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-27-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg Montg. Md.</u>			
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>				ADDRESS <u>Gaithersburg, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11358

CHANCE OF LOSS

11358

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "CHANCE OF LOSS" and "11358" are visible.]

11358

CHANCE OF LOSS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17346		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17357	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <u>Christina</u> First <u>D.</u> Middle <u>Fethe</u> Last			2a. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1968</u>			2b. HOUR <u>4:15 AM</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>8-25-82</u>		6. AGE (In years last birthday) <u>86</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u> Md.	
10. CITY OR TOWN OF DEATH <u>Sykesville, Md</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Factory</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <u>Maryland</u>		13b. COUNTY <u>Baltimore City</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>3639 Dorsey Lane</u>							
14. FATHER'S NAME First <u>Charles</u> Middle <u>Fethe</u> Last <u>Bardroff</u>			15. MOTHER'S MAIDEN NAME First <u>Margaret</u> Middle <u>Bardroff</u> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>220-54-6294</u>		17. INFORMANT <u>Katherine Denbo</u> Address <u>2011 Woodlawn Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic Heart Disease (Chronic)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>398X</u> Days <u>Years</u> <u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>416X</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-19-66</u> , to <u>12-1-68</u> , that (I) (we) last saw the deceased alive on <u>12-1-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Gracito V. Patricio</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>12/1/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Gracito V. Patricio, M.D.</u>				22e. ADDRESS <u>Springfield State Hosp. Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12/4/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem. Fred. Rd. Balt</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Farley Cronaugh</u> ADDRESS				25a. RECEIVED BY REGISTRAR <u>DEC 6 1968</u> DATE		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17347												MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												17358											
1. DECEASED-NAME (Type or print) First Middle ? Last PANZI VIVIAN FINK						2a. DATE OF DEATH 12 Month 16 Day 68 Year						2b. HOUR M																							
3. SEX FEMALE				4. RACE WHITE				5. DATE OF BIRTH ? May 9, 1882				6. AGE (In years last birthday) abt 86 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN															
7a. BIRTHPLACE (State or foreign country) Frederick, Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Carroll Md.																							
10. CITY OR TOWN OF DEATH Winfield				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GOLDEN AGE NURS. HOME				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE				12b. KIND OF BUSINESS OR INDUSTRY NONE																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Carroll				13c. CITY OR TOWN Westminster				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER Route 5 Taylorsville Rd.																			
14. FATHER'S NAME First Middle Last Jerome N. Pompelle						15. MOTHER'S MAIDEN NAME First Middle Last (Unknown)																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT: son Wm. L. Fink, Taylorsville, Rd., Westminster,								Address Carroll Co., Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arterio-sclerosis Second year DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 332X																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from 12/12, 1968, to 12/16, 1968, that (I) (we) last saw the deceased alive on 12/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Harry Deibel M.D.												22c. DATE SIGNED 12/19/68																							
22d. PHYSICIAN'S NAME (Type) Harry Deibel M.D.												22e. ADDRESS 1226 S. Hanover Street																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE Dec. 18, 1968				23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.				23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co., Md.																							
24. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av. Balto. 1												25a. REC'D BY REGISTRAR DATE DEC 18 1968				25b. REGISTRAR'S SIGNATURE Charles Judge																			

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17348 CERTIFICATE OF DEATH 17359										
1. DECEASED-NAME (Type or print) First Middle Lost Robert Buchanan French, Jr.					2a. DATE OF DEATH Month Day Year December 18, 1968			2b. HOUR 8:50 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-4-89		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 36 Nottingham Road			
14. FATHER'S NAME First Middle Lost Robert Buchanan French, Sr.					15. MOTHER'S MAIDEN NAME First Middle Lost Katy Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 213-16-1927		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days		
								Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201								Years		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-6-</u> , 19 <u>68</u> , to <u>12-18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-16-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Glocrito Sagisi</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-18-68			
22d. PHYSICIAN'S NAME (Type) Glocrito Sagisi, M.D.					22e. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE DEC. 21, 68		23c. NAME OF CEMETERY OR CREMATORY Salem Reformed Cem.			23d. LOCATION (City or Town) (County) (State) Cearfoss (Wash.) Md.			
24. FUNERAL DIRECTOR A. K. Coffman Funeral Home Inc.					ADDRESS 40 E. Antietam St. Hagerstown Md.		25a. REC'D BY REGISTRAR DEC 26 1968		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last Clara Elizabeth Lingeman FREY			2a. DATE OF DEATH Month Day Year December 24 1968			2b. HOUR M
3. SEX Female	4. RACE White		5. DATE OF BIRTH 1-6-81			6. AGE (In years lost birth day) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13e. STREET AND NUMBER 716 Dunloggin Road			
14. FATHER'S NAME First Middle Last Henry B. Lingeman			15. MOTHER'S MAIDEN NAME First Middle Last Isabelle Lowe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of right leg</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease with</u> DUE TO, OR AS A CONSEQUENCE OF <u>severe peripheral insufficiency</u> (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> , 19 <u>68</u> , to <u>12-24</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>12-24-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Antonius Glahn					22c. DATE SIGNED 12-24-68		22d. PHYSICIAN'S NAME (Type) Antoniuss Glahn, M.D.		
22e. ADDRESS Springfield State Hospital									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 27, 1968		23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry Witzke					25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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17350

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17361

1. DECEASED-NAME (Type or print) First Middle Last James Carlin Fulton			2a. DATE OF DEATH Month Day Year December 24, 1968		2b. HOUR A.M. 12:05
3. SEX Male	4. RACE White	5. DATE OF BIRTH February 11, 1888	6. AGE (In years last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CARROLL Md.		
10. CITY OR TOWN OF DEATH SYKESVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRINGFIELD STATE HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore Co.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 101 Forest Drive	
14. FATHER'S NAME First Middle Last WILLIAM FULTON	15. MOTHER'S MAIDEN NAME First Middle Last EMMA CARLIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No	16b. SOCIAL SECURITY NO. 220-56-9557-J	17. INFORMANT Address 1 Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4129 DUE TO, OR AS A CONSEQUENCE OF (c) 4200					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) phrase CBS assoc. with circulatory disturbance with cerebral art. without qualifying					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that 19 (this hospital) attended the deceased from 10/15/ , 19 57 , to 12/24 , 19 68 , that 1 (we) last saw the deceased alive on 12/24 , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above. 1 (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. Patricio	DEGREE M. D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/24/68		
22d. PHYSICIAN'S NAME (Type) G. Patricio, M. D.	22e. ADDRESS Springfield State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-26-68	23c. NAME OF CEMETERY OR CREMATORY ST Johns	23d. LOCATION (City or Town) (County) (State) ELlicott City Md.		
24. FUNERAL DIRECTOR Higginbotham Slack		ADDRESS Ellicott City, Md.	25a. REC'D BY REGISTRAR DEC 31 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

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THE CASE OF HEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17362

1. DECEASED-NAME (Type or print) Pearl Clifton Twigg GILPIN			2a. DATE OF DEATH Month December Day 7 Year 1968			2b. HOUR 12:30 m.				
3. SEX female		4. RACE white		5. DATE OF BIRTH 7-28-1879		6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland			13b. COUNTY Howard Co		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route #3 21771	
14. FATHER'S NAME First Louis Middle Twigg Last			15. MOTHER'S MAIDEN NAME First Nora Middle Webster Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-05-8840		17. INFORMANT Address Springfield State Hosp. Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) Arteriolosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CBS assocd with senile brain disease with behavioral reaction.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8-21-67 , 19__, to 12-7-68 , 19__, that (I) (we) last saw the deceased alive on 12-7-68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Octavio A Ruiz DEGREE 22d. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-8-68			
22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21781										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Dec. 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Poplar Springs Meth.		23d. LOCATION (City or Town) (County) (State) Poplar Springs, Md.				
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md. ADDRESS					25a. REC'D BY REGISTRAR DATE DEC 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

11863

11871

UNITED STATES DEPARTMENT OF JUSTICE



8381 81030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
304 REV. 1-64

17352				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17363						
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR			
MAURICE EDWARD GRAY							Dec	Month	24	Day	1968	Year	7 P	M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
M		W		MARCH 12 - 1902			66 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		Md.						
MARYLAND		USA		WIDOWED		CARROLL								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
WESTMINSTER		GENERAL			LABORER WELDER			RAILROAD						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
MARYLAND		CARROLL		UNION BRIDGE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14 S MAIN ST.						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT						
CHARLES E GRAY		EMMA MYERS		NO		705-10-6742		PAULINE GRAY UNION BRIDGE MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
4201 Cerebral Vascular accident														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year		(Enter nature of injury in Part 1 or Part 2, Item 18.)		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)								
(If either, notify medical examiner)		P.M. 19				21f. LOCATION Street or R.F.D. No. City or Town County State								
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION								
While <input type="checkbox"/> Not while <input type="checkbox"/>		(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		Street or R.F.D. No.		City or Town		County		State				
at work <input type="checkbox"/> at work <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 23, 1968</u> , to <u>Dec 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
John S. Harshey, M.D.		12/24/68		JOHN S. HARSHEY, M.D.		8 Archer St. Westminster, Md.								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS								
JOHN S. HARSHEY, M.D.		8 Archer St. Westminster, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)								
BURIAL		12/27/68		MT VIEW		UNION BRIDGE MD								
24. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE								
D D Hartzler & Sons Union Bridge		DEC 30 1968		Charles Judge										

13363

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17353										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17364																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										HOURS MIN.																																							
NORA										EVA. GRIMES										DECEMBER 25 1968										8:45 M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										JAN 20 1887										81 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										USA.																				Carroll																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Manchester										Long View Nursing Home										Housewife										Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Maryland										CARROLL										Middleburg										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										NONE																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
Charles										BOWMAN										RACHAEL										Flickinger																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT Address																																							
No										No										212-24-5973										Mrs CARRIE C SAYLER UNION BRIDGE MD																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Cerebral Vascular Hemorrhage										12-23-68																																							
4120																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Hypertensive Cardio Vascular Disease																																																	
										(c) Arteriosclerotic Cardio Vascular Disease																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
443 X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Dec 13, 1968, to Dec 25, 1968, that (I) (we) last saw the deceased alive on Dec 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																													
Joseph E Bush																														Dec 25, 1968																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Joseph E Bush MD										Hampstead Maryland																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										12/28/68										METHODIST CEM										MIDDLEBURG MD																													
23a. FUNERAL DIRECTOR										23b. ADDRESS										23c. REC'D BY REGISTRAR										23d. REGISTRAR'S SIGNATURE																													
W. Hatcher & Sons Union Bridge MD																				DEC 31 1968										J Charles Judge																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) Mary Elizabeth L. Gunzelman						2a. DATE OF DEATH 12 Month 4 Day 68 Year			2b. HOUR 1:25 PM			
3. SEX female		4. RACE white		5. DATE OF BIRTH 7/26/90			6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Rural--Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) dressmaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 451 N. Milton Avenue		
14. FATHER'S NAME First Middle Last George - Gunzelman				15. MOTHER'S MAIDEN NAME First Middle Last Margaret - Dietz								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 220-54-3010		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4330 (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Schizophrenic reaction, hebephrenic type.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that he (this hospital) attended the deceased from 3/20/ , 19 47 , to 12/4/ , 19 68 , that we (we) lost saw the deceased alive on 12/4/ , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above. he (we) did (did not) view the body after death.												
22b. SIGNATURE Renato R. Espina		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/4/68						
22d. PHYSICIAN'S NAME (Type) Renato R. Espina, M. D.		22e. ADDRESS Springfield State Hospital Sykesville, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/7/68.		23c. NAME OF CEMETERY OR CREMATORY only Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.						
24. FUNERAL DIRECTOR Leonard J. Muck, Inc. Balto. Md. 21214		ADDRESS		25a. RECORD BY REGISTRAR DEC 11 1968		25b. SIGNATURE [Signature]						

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7-7-20-1980 100-0-130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-68

17355		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17366		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
James B. Haines Sr.						Dec 18 1968		5:04 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
M		White		June 27, 1897		71 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Staunton Va.		U.S.A.				Baltimore Carroll Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
New Windsor Md.		R.F.D. Rt. 1, New Windsor		Ret. Printer		Self Emp.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.		Carroll County		New Windsor		Rt. 1 Box 96 A. 21176		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		
Robert O. Haines						Ella Dox Staples		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO			413-14-1207		Mrs. Ester L. Haines Rtl, Box 96 A, New Windsor			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> 1533 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma - sigmoid</u> DUE TO, OR AS A CONSEQUENCE OF (c)								Years 1 Year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
1533								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/30/68</u> 19, to <u>12/18/68</u> 19, that (I) (we) last saw the deceased alive on <u>12/18/68</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>M. E. Robertson M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS		<u>12/18/68</u>
						<u>New Windsor Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Dec. 21, 68		Lake View Memorial Park		Liberty Rd. Baltol Co. Md.		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Loring Byers 8728 Liberty Rd. Randallstown.						DATE DEC 23 1968		<u>Charles Young</u>

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COULSON

711 . 0 0 I.J. 70000 *** II-rrr

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

17356		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17367	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
William		Walter	Hare, Sr.	Dec.	Month	Day	Year
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
Male		Cau.		May 26, 1897		71 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md.		U.S.A.		Baltimore Co.		Carroll Co. Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hampstead		R.F.D. Upper Beckleysville Rd.		Farmer		Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		Carroll Baltimore		Hampstead		Upper Beckleysville Rd.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First
Theodore		L.	Hare	Della	V.	FAIR	Fair
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		220-03-2947		Donald E. Hare Dave Rill Rd. Hampstead, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u>							<u>Instant</u>
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Insufficiency</u>							<u>3 yrs.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Old Cardiac Infarction</u>							<u>14 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6-5, 1959, to 12-5, 1968, that (I) (we) last saw the deceased alive on 12-30, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE M.C. Porterfield		DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-6-68	
22d. PHYSICIAN'S NAME (Type) M.C. Porterfield		22e. ADDRESS Hampstead, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Dec. 8, 1968		St. Abraham's Luth. Church		Hampstead Balto. Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John E. Goff		324 N. Main St.		DATE DEC 9 1968		Charles Judge	
John E. Goff Funeral Home		Hampstead, Md.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17357

17368

1. DECEASED-NAME (Type or print) Forrest Glen Harrison			2a. DATE OF DEATH Month Dec. Day 30 Year 1968			2b. HOUR 5:45 A.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MARCH 8, 1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____ IF UNDER 24 HRS. HOURS _____ MIN. _____			
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route 32			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machanic			12b. KIND OF BUSINESS OR INDUSTRY Auto		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 32		
14. FATHER'S NAME First Middle Last Charles - Harrison			15. MOTHER'S MAIDEN NAME First Middle Last Rosella - Shook								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) No (If yes give war or dates of service) -			16b. SOCIAL SECURITY NO. 214-05-5379		17. INFORMANT Address Mrs. Vesta Harrison - Sykesville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma colon, with liver 1538 DUE TO, OR AS A CONSEQUENCE OF involunt intestinal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) obstruction and fistula formation DUE TO, OR AS A CONSEQUENCE OF (c) anorexia bronchial pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1962 thru 1968											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from Dec. , 19 62 , to Dec 30 , 19 68 , that (I) (we) last saw the deceased alive on Dec. 30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Howard E. Hall						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-30-68			
22d. PHYSICIAN'S NAME (Type) HOWARD E. HALL M.D.						22e. ADDRESS Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 12-2-69		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			23d. LOCATION (City or Town) (County) (State) York Pa.			
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.						25a. REC'D BY REGISTRAR DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

17838
JAN 1 1968
JAN 1 1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>Item#2aF11m#G408 12/3</div> <div>17358</div> <div>17369</div>											
<div>1. DECEASED-NAME (Type or Print) FRANCIS ELMER HARRISON</div> <div>2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 19 Year 1968</div> <div>2b. HOUR M</div>											
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1877? 1880?		6. AGE (In years last birthday) 91? 88? YRS.		7c. DATE PRONOUNCED DEAD Month DECEMBER Day 19 Year 1968		2d. HOUR 10:00 AM	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll				Md.	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2005 Dennison St.			
14. FATHER'S NAME First John Middle Harrison Last Netti		15. MOTHER'S MAIDEN NAME First Netti Middle Unk. Last Unk.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.		16b. SOCIAL SECURITY NO. 215-05-5318		17. INFORMANT Records, Springfield State Hospital		ADDRESS					
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Uremia</div> <div>403X DUE TO, OR AS A CONSEQUENCE OF</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 446X</div> <div>(b) Nephrosclerosis</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div>										<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>Days</div> <div>Years</div>	
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div>Fracture, right ankle. Bronchopneumonia.</div>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 11:40 AM 12-1-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Fell in hallway, Convalescent #1							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Springfield State Hospital, Sykesville, Maryland, Carroll		21f. LOCATION Street or R.F.D. No. Sykesville City or Town Carroll County Carroll State Md.							
<div>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div>ACTUAL SIGNATURE W. Glenn Speicher M.D.</div> <div>EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.</div> <div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>22b. DATE SIGNED 12-19-68</div>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-21-68		23c. NAME OF CEMETERY OR CREMATORY Westly Freedom		23d. LOCATION (City or Town) Sykesville (County) Md. (State) Md.					
24. FUNERAL DIRECTOR Harry W. Haight ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DEC 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 Film 408 1-22-69an MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17359 CERTIFICATE OF DEATH 17370									
1. DECEASED-NAME (Type or print)			First Middle Last Joseph Henry Heitman			2a. DATE OF DEATH Month 26, Day 1968 Year		2b. HOUR P 10:45M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-3-97		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sculptural-Iron worker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE General Delivery, U.S.A.		13c. CITY OR TOWN 19b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER fixed address			
14. FATHER'S NAME First Middle Last unk.			15. MOTHER'S MAIDEN NAME First Middle Last unk.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) unk.		16b. SOCIAL SECURITY NO. 120-01-4036A		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Arteriosclerotic cardiovascular disease. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CBS, associated with alcohol intoxication with psychotic reaction									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-21, 1954, to 12-26, 1968, that (I) (we) last saw the deceased alive on 12-26-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Octavio A. Ruiz, M.D.				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-27-68	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.				22e. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-1-69		23c. NAME OF CEMETERY OR CREMATORY Wesley Freedom		23d. LOCATION (City or Town) (County) (State) Sykesville Md.			
24. FUNERAL DIRECTOR Harry Haight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 Film 407 12-16-68										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17371									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										M									
Melvin Alverta Hill										12 7 68										215p									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			White			1-13-75			93			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			U.S.A.						Carroll																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Sykesville			Springfield State Hosp.			Housewife																							
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland			Monte			Carroll Westminster						Church St. Methodist Home																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
First Middle Last			First Middle Last																										
Henry Shipley			Frances Anna Conway																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																				
No			218-52-3290			Records			Springfield State Hosp. Sykesville Md.																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:										Days																			
IMMEDIATE CAUSE (a) <u>Pneumonia</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4221</u>										(b) <u>Arteriosclerotic Cardiovascular disease</u> Years																			
DUE TO, OR AS A CONSEQUENCE OF										(c) <u>reaction</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
<u>Chronic brain syndrome associated with senile brain disease with psychotic</u>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-19-66</u> , 19 <u>66</u> , to <u>12-7-68</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12-7-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																				
Dr. Antonius Glahn			12-7-68			Antonius Glahn			Springfield State Hosp. Sykesville, MD.																				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
Burial			12/10/68			Westminster, Maryland			Westminster, Md.																				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																							
J. S. Myers, Jr.			DEC 11 1968			J. S. Myers, Jr.																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Lawrence Leroy Hoffman					2a. DATE OF DEATH Month Dec Day 25 Year 1968		2b. HOUR 1:40 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 30, 1892		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Hospt.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Railroad		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rd 2	
14. FATHER'S NAME First Middle Last Joseph Hoffman				15. MOTHER'S MAIDEN NAME First Middle Last Ida Rice					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 705-10-4921 A		17. INFORMANT Address Mrs. Ella Shamer Rd Finksburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 Uremia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 25, 1968 , to Dec 25, 1968 , that (I) (we) last saw the deceased alive on Dec 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John S. Harshey, MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12/25/68					
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, MD				22e. ADDRESS 8 Anchor St. Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Hampstead, Md.		23d. LOCATION (City or Town) (County) (State) Hampstead Carroll Co. Md.			
24. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead, Md.				25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

1997, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17362

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17373

1. DECEASED-NAME (Type or print) Ulysses Monroe Holloway			2a. DATE OF DEATH Month 12 Day 7 Year 68			2b. HOUR 4:15 M				
3. SEX male		4. RACE negro		5. DATE OF BIRTH 1 - 14 - 91		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Barber			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1415 Pennsylvania Ave.	
14. FATHER'S NAME First Riley Middle Holloway Last Ross			15. MOTHER'S MAIDEN NAME First Agnes Middle Virginia Last Ross							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) WW 1 (If yes give war or dates of service) WW 1			16b. SOCIAL SECURITY NO. 125 - 01-6853 T		17. INFORMANT Hospital Records -Springfield St. Hosp. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple bed-sores DUE TO, OR AS A CONSEQUENCE OF (c) CBS assoc. with cerebral arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2mons&3wks.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 334x										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 9-17 , 19 68 , to 12-7 , 19 68 , that (I) (we) last saw the deceased alive on 12-7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Paul G. Ensor, M.D.				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 7 Dec 68		
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor M.D.				22e. ADDRESS Springfield State Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec. 11, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.				
24. FUNERAL DIRECTOR Frank H. Newell, Pikesville & Mt.				25a. REC'D BY REGISTRAR DEC 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

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RECORD OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) CECELIA			First B. Middle HOOD Last			2a. DATE OF DEATH Month Dec. Day 12 Year 1968		2b. HOUR A.M. 8:30 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 26, 1884		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Mt. Airy			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R. D. 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R. D. 2	
14. FATHER'S NAME First Henry Middle H. Last Mullinix			15. MOTHER'S MAIDEN NAME First Mary Middle E. Last Daley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218-52-2485		17. INFORMANT Address Mrs. Frank Byers Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 20yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April, 1951 , to Dec, 1968 , that (I) (we) lost saw the deceased alive on Oct. 7 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W.B. Culwell M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Dec. 12, 1968			
22d. PHYSICIAN'S NAME (Type) Dr. W. B. Culwell					22e. ADDRESS Mt. Airy, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/14/1968		23c. NAME OF CEMETERY OR CREMATORY Taylorville		23d. LOCATION (City or Town) (County) (State) Taylorville, Carroll, Md.				
24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Box 241, Sykesville, Md.					25a. REC'D BY REGISTRAR DATE DEC 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First LYDIA		Middle (NMN)		Last HOPF		2a. DATE OF DEATH Month Day Year DECEMBER 2, 1968		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-22-1884			6. AGE (In years last birthday) 84 YRS.		2b. HOUR 5:40 P		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll			Md.		
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5615 Laurelton Road			
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212-03-8860-D			17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery sclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CBS associated with senile brain disease, without qualifying phrase											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>7-16-68</u> , 19 <u> </u> , to <u>12-2-68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12-2-68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Isak E. Hapner</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-2-68			
22d. PHYSICIAN'S NAME (Type) Isak E. Hapner, M. D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/4/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION (City or Town) (County) (State) Woodlawn Balto. Co. Md				
24. FUNERAL DIRECTOR KRAUSE FUNERAL HOME				ADDRESS 12163 Charles St.		25a. REC'D BY REGISTRAR DATE DEC 5 1968		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Mazie E. Kexel</i>			2a. DATE OF DEATH Month Day Year <i>December 2 1968</i>			2b. HOUR <i>6:00 A. M.</i>			
3. SEX <i>Female</i>		4. RACE <i>Cau.</i>		5. DATE OF BIRTH <i>September 5 1887</i>		6. AGE (In years last birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>			
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>84 Uniontown Rd.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>84 Uniontown Road</i>	
14. FATHER'S NAME First Middle Last <i>Grandville Leese</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Almeda Krumrine</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>215-20-9677</i>		17. INFORMANT <i>Mrs. Andrew Dietrich</i> Address <i>84 Uniontown Road Westminster Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis, suspected</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>332X</i> (b) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>acute</i> <i>unknown</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic cardiovascular disease, gastroenteritis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/30</i> , 19 <i>63</i> , to <i>12-2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Philip W. Mercer</i> M.D.				22c. DATE SIGNED <i>12/2/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Philip W. Mercer</i>			
22e. ADDRESS <i>150 W. Main St Westminster Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>December 4, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Shermans Church Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Hanover R.D. 1 Penna.</i>			
24. FUNERAL DIRECTOR <i>John E. Gott</i>				ADDRESS <i>324 N. Main St Hampstead</i>		25a. REC'D BY REGISTRAR <i>DEC 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John E. Gott</i>	

12378

RECORD OF DEATH

RECORD OF DEATH

12378

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17377

1. DECEASED-NAME (Type or print) Bertha Wilmering KUHFUSS			20. DATE OF DEATH Month December Day 30 Year 1968			2b. HOUR 6:55 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-13-98		6. AGE (In years lost birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? Germany		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 600 South Streeper Street	
14. FATHER'S NAME First Frank Middle Wilmering			15. MOTHER'S MAIDEN NAME First Minnie Middle Kuhlmann						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-56-0118		17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Schizophrenic reaction, other and unspecified									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-21-1933 to 12-30-1968 , that (I) (we) last saw the deceased alive on 12-30-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Francisco J. Ceballos M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 12-30-68			
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M.D.						22e. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN. 9 '69		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) BALTIMORE Md.			
24. FUNERAL DIRECTOR Frank H. Sewell Jr. Pikesville ADDRESS						25a. REC'D BY REGISTRAR DATE JAN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <i>George</i>	Middle <i>BERNARD</i>	Last <i>Lippy</i>	2a. DATE OF DEATH 12 Month 10 Day 68 th year	2b. HOUR 8 4 M
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>May 2, 1897</i>		6. AGE (In years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Ind-</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>		
10. CITY OR TOWN OF DEATH <i>Monkton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>128 W. Main St. Ingrown Nursing Home, Petros Cattle Dealer</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <i>Ind.</i>	13b. COUNTY <i>Carroll Ind.</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Rd #1</i>		
14. FATHER'S NAME First <i>Jonas</i> Middle <i>Lippy</i> Last <i>Clara</i>		15. MOTHER'S MAIDEN NAME First <i>Clara</i> Middle <i>Hayley</i> Last <i>Hayley</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes WWI</i>		16b. SOCIAL SECURITY NO. <i>218-32-3489</i>		17. INFORMANT <i>Elizabeth Lippy wife of Westminster Rd #1, Ind</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Head Pancreas</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>C Liver metastases jaundice</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>+ Cachexia</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 to 1 1/2 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>1578</i>						
19a. DATE OF OPERATION <i>1/28/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cholecyct cholecystomy</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>12-30</i> , 19 <i>67</i> , to <i>12-10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-9</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>William Speicher</i>				22c. DATE SIGNED <i>12-10-68</i>		22d. PHYSICIAN'S NAME (Type) <i>Westminster Ind</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/13/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Winters Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>New Windsor, Carroll Ind.</i>
24. FUNERAL DIRECTOR <i>E. E. Myers Jr., Westminster, Md</i>				25a. REC'D BY REGISTRAR <i>DEC 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 14 & 15

Film 408

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17379

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17379

1. DECEASED NAME (Type or Print) Hurley		First FLOYD		Middle FLOYD		Last HURLEY		2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> December 23,		2b. HOUR 19	
3. SEX male	4. RACE white	5. DATE OF BIRTH Oct. 29, 1915	6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0	2c. DATE PRONOUNCED DEAD Month December Day 23, Year 19 68	2d. HOUR 2:20 P.M.		
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hosp.	
12a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission - STATE) Maryland		13a. CITY OR TOWN Carroll		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET AND NUMBER 9211 Turnbull Road		12b. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) programer		12c. KIND OF BUSINESS OR INDUSTRY social security	
14. FATHER'S NAME John		First unknown		Middle Clarence		Last Lyle		15. MOTHER'S MAIDEN NAME Ivy Clover		First unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) WW1		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 161 18 8291		17. INFORMANT Louise K. Lyle		ADDRESS 9211 Turnbull Rd., 21133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8160 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8244											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. UNK P.M. UNK 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of car - went out of control, thrown out of car			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ Carroll, Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner KU Spitz				M.D. Werner KU Spitz, M.D.				22b. DATE SIGNED 12/24/68			
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE 12 27 1968				23c. NAME OF CEMETERY OR CREMATORY Lakeview Cem.			
24. FUNERAL DIRECTOR Loring Byers				ADDRESS 8728 Liberty Rd; Randallstown, Md.				25a. REC'D BY REGISTRAR DEC 30 1968			
								25b. REGISTRAR'S SIGNATURE J Charles Judge			

201. 5. 30. 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH				2b. HOUR	
Nellie R. MANGPT					Dec	Month	Day	Year	5:45	P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
female		white		Feb 12-1887		87		MONTHS		HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Westminster		USA				Carroll				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Manchester				Lp. N. G. V. 128 N. Main				Housewife		Housewife
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland				Carroll		Westminster		YES		129 Penna Ave
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Charles			Bowers		Maggie Fable					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT				
No						Miss Wm J. Crabbe 258 Washington Rd Westminster, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cerebrovascular Accident										2 MONTH
4129 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) Generalized Atherosclerosis										5 Yr
DUE TO, OR AS A CONSEQUENCE OF										
(c) Atherosclerotic Heart Disease										5 Yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										
4200										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 7/9, 1962, to 12/26, 1962, that (I) (we) last saw the deceased alive on Dec 20, 1962, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
W. H. Foard M.D.										12/26/68
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
W. H. Foard M.D.						25 N. Main St Manchester, Md 21102				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		12/28/68		KRIDERS CEMETERY			WESTMINSTER CARROLL, MD			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
J. E. Myers, Jr. Westminster, Md.								DEC 30 1968		Charles Judge

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DEC 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
17370		WILLIAM		H.		MAY, SR.		Dec Month 30 Day 1968 Year		5:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost, birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Sept. 10, 1904		64 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Westminster		Carroll Co. Gen. Hospital		Bin Operator		Quarry					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Carroll		New Windsor				Route 1			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
John		W.		May				Grace		Bohn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		215-20-9692		Mrs. Melinda R. May		Same As #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u> <u>Chronic bronchitis & pulmonary emphysema</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29, 1968</u> , to <u>12/30, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>John S. Harshey, M.D.</u>				<input checked="" type="checkbox"/>				<u>12/30/68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
JOHN S. HARSHEY, M.D.		8 Anchor St. Westminster, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		1/2/1969		Taylorsville		Taylorsville, Carroll, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C.M. Waltz, Box 241, Sykesville, Md.				DATE JAN 2 1969		<u>Charles Judge</u>					

VR 12-14
3044 REV. 3-68

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17371				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17382					
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR		
WILLIAM				LEO		McDONALD	Month 12 Day 3 Year 68		5:30				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		Caucasian		08/06-97			71 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				Md.		
Dist of Col.		U.S.A.					CARROLL						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
SYKESVILLE			Springfield State Hosp.			Plumber			PLUMBING				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Montg. Co.			Silver Sp.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9912 Capitol View Ave.			
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last
Samuel McDonald							Ella Chester						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.			17. INFORMANT						
No				577-10-6258			Hospital Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) - <i>Uremia</i>													
4129 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221													
(b) <i>Congestive Heart Failure</i>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <i>Arteriosclerotic cardiovascular disease</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
<i>CBS assoc with cerebral arteriosclerosis with psychotic reaction</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year										
			P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work							Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 07/18/68, 19__, to 12/3/68, 19__, that (I) (we) last saw the deceased alive on 12/3/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE							DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
<i>Harold P. Jager</i>											12/3/68		
22d. PHYSICIAN'S NAME (Type)							22e. ADDRESS						
G. G. Sagisi, M.D.							Springfield State Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL			12-7-1968		MT. OLIVET CEM			WASHINGTON, D.C.					
24. FUNERAL DIRECTOR							ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W.W. CHAMBERS, INC.							SILVER SPRING, MD		DEC 6 1968		<i>J. Charles Jager</i>		

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VR A15 (4)
30M REV. 1/68

17372

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17383

1. DECEASED-NAME (Type or print) Elijah		First Middle Last (NMN) MILLER		2a. DATE OF DEATH Month Day Year December 23, 1968		2b. HOUR 11:45 PM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 3-23-88 ?		6. AGE (In years last birthday) 80? YRS.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER NO FIXED ADDRESS		14. FATHER'S NAME First Middle Last Wiley Miller		15. MOTHER'S MAIDEN NAME First Middle Last Ellen Edmund			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220 24 2232		17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS, associated with central nervous system syphilis with psychotic reaction							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-6-1963 , to 12-23-1968 , that (I) (we) last saw the deceased alive on 12-23-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Octavio A. Ruiz, M.D.		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-24-68	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22e. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-29-68		23c. NAME OF CEMETERY OR CREMATORY St. Luke Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.	
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF HEALTH

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1. DECEASED-NAME (Type or print) Paul Herman Miller		2a. DATE OF DEATH Month 12 Day 24 Year 68		2b. HOUR P 6:00 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3/16/95	6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Carroll Md.	
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Office Worker-Crown, Cork & Seal	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Balt. City	13c. CITY OR TOWN Balt. City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 303 Whitridge Avenue
14. FATHER'S NAME First Middle Last XXXXXXXX William Miller	15. MOTHER'S MAIDEN NAME First Middle Last XXXXXXXX Margaret Krause		Address (Same) Mrs. Beatrice B. Miller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO. 212-09-8166	17. INFORMANT (Hospital Records) Mrs. Beatrice B. Miller		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 354X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) C.B.S. Associated with cerebral arteriosclerosis with psychotic reaction.				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (a) this hospital attended the deceased from 1/31 , 19 65 , to 12/24 , 19 68 , that (a) (we) lost saw the deceased alive on 12/24 , 19 68 , and that in (b) (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Isak E. Harper	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/24/68		
22d. PHYSICIAN'S NAME (Type) ISAK, E. HARPER	22e. ADDRESS Springfield State Hosp. Sykesville, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/27/68	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	ADDRESS 4905 York Rd. Balto. 12, Md.	25a. REC'D BY REGISTRAR DEC 26 1968	25b. REGISTRAR'S SIGNATURE [Signature]	

1. The first of these is the fact that the

second of these is the fact that the

third of these is the fact that the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17374

17385

1. DECEASED-NAME (Type or print) First Middle Last L L L L BERTHA MOHL HENRICH			2a. DATE OF DEATH Month Day Year Dec 29 1968			2b. HOUR 10 ²⁰ P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 3-2-1880		6. AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN SYKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER None		14. FATHER'S NAME First Middle Last HENRY MOHL HENRICH		15. MOTHER'S MAIDEN NAME First Middle Last AMELIA WERNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address HOSPITAL RECORDS.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 4201 Central vascular insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/11, 1968, to 12/29, 1968, that (I) (we) lost saw the deceased alive on 12/29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John S. Harshey, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12/29/68			
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY				22e. ADDRESS 8 Anchor St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-31-68		23c. NAME OF CEMETERY OR CREMATORY J. W. LEE'S SONS		23d. LOCATION (City or Town) (County) (State) WASH. D.C.	
24. FUNERAL DIRECTOR Arthur A. Haight Sykesville, Md.				25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

1932

RECEIVED

1932



JAN 3 1932
JAN 3 1932

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17375

17386

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) JIMMY CARSON MOORE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 24 Year 1968			2b. HOUR 5:30 AM			
3. SEX Male	4. RACE Colored	5. DATE OF BIRTH 11-27-46	6. AGE (In years last birthday) 22 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 12 Day 24 Year 1968			
7a. BIRTHPLACE (State or foreign country) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll				
10. CITY OR TOWN OF DEATH Henryton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) —			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) —		12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY —		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 941 Ashburton St.	
14. FATHER'S NAME Arthur TOWNS			15. MOTHER'S MAIDEN NAME JONIE TOWNS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. —			17. INFORMANT Juliette Moore			
						ADDRESS same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 823.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. choking (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 823.4									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 5:30 PM 12-24-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Ran off Road + into Pond + Gunter					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital Grounds		21f. LOCATION Street or R.D. No. City or Town County State Henryton Rd Henryton Carroll Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE William Speicher				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 12-24-68	
EXAMINER'S NAME (Type) William Speicher				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS Street and City, State, Zip 135 E. Main St. Westminster Carroll Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-29-68		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Hk.		23d. LOCATION (City or Town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR Wilmington Phillips				ADDRESS 17270 Mount St		25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

DEC 10 1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If possible, remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
30M REV. 1-68

173876

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17387

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
NORA				Virginia	Mumaw	Month	Day	Year	8 ³⁰ A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		11-22-95		73 YRS.		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Virginia		USA.				CARROLL					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
SYKESVILLE		SPRINGFIELD STATE HOSPITAL		BEAUTICIAN		Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Kensington				3513 BAYVIEW RD. Kensington Md			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Lemuel				Ryman		SARAH				ESTEP	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			578-464525			SPRINGFIELD STATE HOSP			Sykesville Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 491X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 11-27, 1968, to 12-25, 1968, that (I) (we) last saw the deceased alive on 12-25-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jose Chappelle						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-25-68			
22d. PHYSICIAN'S NAME (Type) Jose Chappelle						22e. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-27-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland Prince George's Md.					
24. FUNERAL DIRECTOR Pumphrey						ADDRESS 7557-Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

17383

CENTRAL OF DEATH

17383

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Residence		Date of Birth		Date of Death		Cause of Death		Place of Death		Time of Death		Manner of Death		Signature		Date	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year				2b. HOUR M		
RUSSELL				LEON	MUMMAUGH		Dec 26 1968				7:45		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
MALE		WHITE		JULY 17 1916			52 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
MARYLAND		U.S.A.						CARROLL CO.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
WESTMINSTER			CARROLL CO. GEN. HOSP.			LARDER							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
MARYLAND		CARROLL		WESTMINSTER				RD #4					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last				
EARL W.		MUMMAUGH			MINNIE BELL ARBAUGH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address							
NO		?		MRS. MILDRED R. NULL		WESTMINSTER, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4339</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>332x</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
John S. Harshey, MD		12/26/68				JOHN S. HARSHEY, MD		8 Archer St. Westminster, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
BURIAL		12/29/68		BETHEL CEMETERY		FINNSBURG, MD (CARROLL, MD)							
24. FUNERAL DIRECTOR		24b. ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
J. S. Myers, Jr., Westminster, Md.						DEC 30 1968		Charles Judge					

8330

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17389

1. DECEASED-NAME (Type or print) Elmer			First Middle Lost I. Pearson			2a. DATE OF DEATH Month 12 Day 27 Year 68			2b. HOUR 8:55AM						
3. SEX Male			4. RACE White			5. DATE OF BIRTH 9-7-00			6. AGE (In years lost birthday) 68 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New Jersey			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll County,			Md.			
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Loan company mgr.			12b. KIND OF BUSINESS OR INDUSTRY Loan Co.						
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 261 North Centre Street			
14. FATHER'S NAME Israel			First Middle Lost Pearson			15. MOTHER'S MAIDEN NAME First Matilda			Middle Carlson			Lost XXXXXX			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-05-4085			17. INFORMANT Springfield State Hospital records			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks			
DUE TO, OR AS A CONSEQUENCE OF 4129 (b) Arteriosclerotic heart disease.												years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4200 (c) Generalized arteriosclerosis. Pulmonary emphysema.												years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. psychotic reaction Chronic brain syndrome associated with cerebral arteriosclerosis, with/															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 11-8 , 19 67 , to 12-27 , 19 68 , that (I) (we) last saw the deceased alive on 12-27-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Maile Lucetola no.			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-27-68						
22d. PHYSICIAN'S NAME (Type) M. Sucholeiki, M.D.			22e. ADDRESS Springfield State Hospital Sykesville, Maryland												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-30-68			23c. NAME OF CEMETERY OR CREMATORY Lombardy Cem.			23d. LOCATION (City or Town) (County) (State) Wilmington, N. C., Delaware						
24. FUNERAL DIRECTOR Harry W. Haight			ADDRESS Sykesville, Md.			25a. REC'D BY REGISTRAR DATE DEC 31 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						

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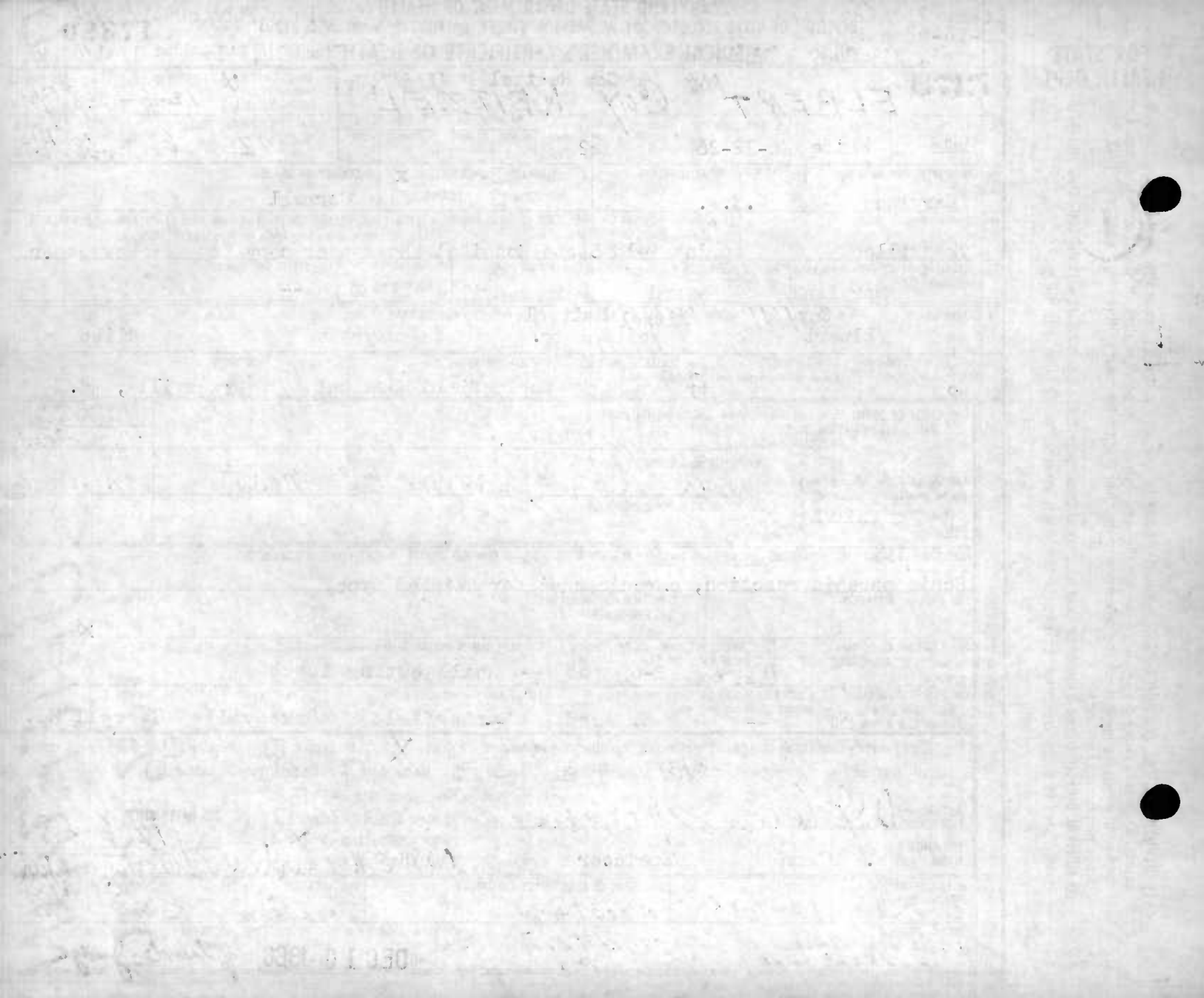
DEC 31 1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item#1, FilmG409 1/31/69 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item#14, FilmG409 1/31/69													
1. DECEASED NAME First ELBERT Middle COY Last REITZEL, Jr						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 6 Year 1968							
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6-12-26		6. AGE (In years last birthday) 42 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll				
10. CITY OR TOWN OF DEATH Sykesville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Newspaper copy boy				12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Simpsonville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER --			
14. FATHER'S NAME First Elbert Middle COY Last REITZEL Sr.						15. MOTHER'S MAIDEN NAME First Myrtle Middle Plitt Last Plitt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 2		17. INFORMANT Springfield Hospital				ADDRESS Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 911X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9217 (b) occlusion of larynx by meat DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, chronic undifferentiated type													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 11:4 PM 2-6 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) -- While eating lunch							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) E. Ward				21f. LOCATION Street or R.F.D. No. Springfield		City or Town Sykesville		County Carroll Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Glenn Speicher EXAMINER'S NAME (Type) W. Glenn Speicher						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles West							
23a. BURIAL, CREMATION, DISPOSITION (Specify) Burial						23b. DATE 12-9-68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) Woodlawn Balto Md.			
24. FUNERAL DIRECTOR Ellicott City Md.						25a. REC'D BY REGISTRAR DEC 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17380		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17391	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
CLINTON			JOHN	ROCHE	SR.	DECEMBER 19, 1968	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		White		7-31-17		51 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				Carroll Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville		Springfield State Hospital		Heating & Plumbing Maintenance Worker - self-employed			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission, STATE)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore City		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	
Henry J. Roche		Elizabeth Smith		Yes		218-07-2600	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u>		19. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Records, Springfield State Hospital						days/weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)		4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-26-66</u> , 19 <u> </u> , to <u>12-19-68</u> , 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>12-19-68</u> 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Octavio A. Ruiz, M.D.</u>		22c. DATE SIGNED 12-19-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS			
Octavio A. Ruiz, M. D.		Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		12/23/68		Balto. Nat. Cem.		Baltimore, Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schimmek Funeral Home		3331 Brehms Lane		f Charles Judge			
XXXXXX		DATE		DEC 24 1968			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
173881 CERTIFICATE OF DEATH 17392									
1. DECEASED-NAME (Type or print) First Middle Last Lloyd Raphael SANDERS						2a. DATE OF DEATH Month Day Year December 14, 1968		2b. HOUR 9 a. M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH 10-6-1904		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		Md.	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Lanids Machine			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington Co.		13c. CITY OR TOWN Highfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 16	
14. FATHER'S NAME First Middle Last Harry L. Sanders				15. MOTHER'S MAIDEN NAME First Middle Last Catherine Sanders					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 162-09-7371		17. INFORMANT Address Springfield State Hosp. Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) Septicemia. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 (b) Multiple infected bed sores. DUE TO, OR AS A CONSEQUENCE OF (c) Severe arteriosclerotic cardio-vascular disease. years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus. CBS assoc. with cerebral arteriosclerosis with behavioral reaction.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 6-20-68 , 19____, to 12-14-68 , 19____, that (X) (we) lost saw the deceased alive on 12-14-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Antonius Glahn DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-14-68			
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.				22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/17/1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary Cemetery		23d. LOCATION (City or Town) (County) (State) Fairfield Adams Penna.			
24. FUNERAL DIRECTOR Samuel Y. Gove				ADDRESS Waynesboro, Pa		25a. REC'D BY REGISTRAR DEC 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/78

17392				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17393			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
1. DECEASED-NAME (Type or print) <i>Walter John Schick</i>				2a. DATE OF DEATH Month <i>December</i> Day <i>28</i> Year <i>1968</i>				2b. HOUR <i>9:15 A</i> M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 26 1893</i>		6. AGE (In years last birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS OAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Indiana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>		Md.			
10. CITY OR TOWN OF DEATH <i>Marionville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Longview Nursing Home 125 N. Main Street</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Government Employee</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Navy</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Hampstead</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>111, Summit Ave</i>			
14. FATHER'S NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>				15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-26-0415 A</i>		17. INFORMANT <i>Lobam Schick</i>		Address <i>Hampstead Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <i>4221</i>											
19a. DATE OF OPERATION <i>4-22-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>4221</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ of work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Office Building</i>		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from <i>7-28-67</i> , 19 <i>67</i> , to <i>12-28</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>12-27-68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Joseph E. Bush MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-28-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		22e. ADDRESS <i>Hampstead Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec. 31, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grace Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Upperco, Md.</i>					
24. FUNERAL DIRECTOR <i>Tipton - Eline Funeral Home Hampstead, Md.</i>				ADDRESS <i>Hampstead, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 31 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17393										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17394																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Catherine - Simpson										12 Month 26 Day 68 Year										5:20 PM																													
3. SEX female										4. RACE white										5. DATE OF BIRTH 10/9/1890										6. AGE (In years last birthday) 78 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Carroll Md.																			
10. CITY OR TOWN OF DEATH Rural--Sykesville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) teacher										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Baltimore										13c. CITY OR TOWN Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 416 N. Broadway									
14. FATHER'S NAME First Middle Last Francis M. Simpson										15. MOTHER'S MAIDEN NAME First Middle Last Mary - McTaggart																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no										16b. SOCIAL SECURITY NO. 220-54-6623										17. INFORMANT Address Springfield Hospital records, Sykesville, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, left lower lobe</u> 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>490X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Schizophrenic reaction, other and unspecified.</u>																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>1/24/1934</u> , to <u>12/26/1968</u> , that <u>we</u> last saw the deceased alive on <u>12/26/1968</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did not) view the body after death.																																																	
22b. SIGNATURE <u>B. Lleras, M.D.</u>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 12/26/68																													
22d. PHYSICIAN'S NAME (Type) <u>R. Lleras, M.D.</u>										22e. ADDRESS Springfield State Hospital Sykesville, Maryland																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 12/30/68										23c. NAME OF CEMETERY OR CREMATORY Loudon Park										23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland																			
24. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc Baltimore, Maryland										25a. REC'D BY REGISTRAR DATE DEC 30 1968										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																													

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CONTINUED OF 17-23

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17394										
17395										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last <i>Margaret Jane Sisson</i>					2a. DATE OF DEATH Month Day Year <i>12 5 68</i>			2b. HOUR <i>9 07 M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 2, 1884</i>			6. AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>			Md.	
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll County General</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Upperco</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Old Hanover Road</i>		
14. FATHER'S NAME First Middle Last <i>William C. Cooper</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Virginia Shachelford</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-10-0588</i>		17. INFORMANT <i>Mr. Frazier F. Sisson</i>			Address <i>Upperco, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> <i>4120</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i> YEARS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>33 HOURS</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>443X</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>12/4</i> , 19 <i>68</i> , to <i>12/5</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/5</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Vincent J. Frazier</i>					22c. DATE SIGNED <i>12/5/68</i>		22d. PHYSICIAN'S NAME (Type) <i>MD</i>			
22e. ADDRESS					22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12/9/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Finksburg, Md.</i>				
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>DEC 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

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DEC 1 1988

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) CATHERINE BESSIE SOCKS						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 9 Year 1968		2b. HOUR 7 M. A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-18-17		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll		
10. CITY OR TOWN OF DEATH Spikesville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY 	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Washington				13b. CITY OR TOWN Hagerstown		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 47 High St.			
14. FATHER'S NAME First Leonard Middle M. Last Stevens						15. MOTHER'S MAIDEN NAME First Nettie Middle Last Dennis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. Unk.		17. INFORMANT ADDRESS Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism 450x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 465x											
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 				21f. LOCATION Street or R.F.D. No. City or Town County State 					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. Glenn Speicher M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.						22b. DATE SIGNED 12-9-68		22c. NAME OF CEMETERY OR CREMATORY St. Paul			
23a. BURIAL, CREMATION, Burial		23b. DATE Dec. 12, 68		23c. NAME OF CEMETERY OR CREMATORY St. Paul				23d. LOCATION (City or Town) (County) Clear Spring, Wash. Md.			
24. FUNERAL DIRECTOR Thompson Funeral Home ADDRESS Clear Spring, Md.						25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MEDICAL & SURGICAL INSTRUMENTS

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Serial Dec. 1, 1968
Johnson County Home Clear Spring, 10.00010 1968
Near Spring, Wash. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

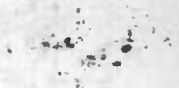
173886				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17397			
1. DECEASED-NAME (Type or print) <i>Gddie PEARL TIPTON</i>				2a. DATE OF DEATH Month <i>December</i> Day <i>9</i> Year <i>1968</i>				2b. HOUR <i>5A</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>August 26 1892</i>				6. AGE (In years lost birthday) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.					
10. CITY OR TOWN OF DEATH <i>Hampstead</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>317 N. MAIN STREET</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>HAMPSTEAD</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>317 N. MAIN</i>			
14. FATHER'S NAME First <i>THOMAS</i> Middle <i>NAYLOR</i> Last <i>IDA</i>		15. MOTHER'S MAIDEN NAME First <i>M.</i> Middle <i>Myers</i> Last <i>Myers</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>214-34-4753</i>		17. INFORMANT Address <i>Mrs MARIE Gill; HAMPSTEAD MD</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>4221</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>March 2, 1958</i> , to <i>December 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>December 8, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Joseph E. Bush MD</i> DEGREE <i>MD</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-9-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>				22e. ADDRESS <i>HAMPSTEAD MARYLAND</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec. 11, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hampstead Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Hampstead Carroll Co. Md.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Tipton - Eline Funeral Home Hampstead, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

1333

REMARKS OF CAPTAIN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17387										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17398									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Raymond Dikeman Tyrrell										Month 12 Day 19 Year 68										9 15 M									
3. SEX Male			4. RACE White			5. DATE OF BIRTH May 17, 1893			6. AGE (In years last birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) Conn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Co. Md.																				
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Trucking																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Owings Mills			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 107 Tollgate Rd.																	
14. FATHER'S NAME First Middle Last Dwight Tyrrell					15. MOTHER'S MAIDEN NAME First Middle Last Annie Daniels Dikeman																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 216-01-7930			17. INFORMANT Mrs. Audrey Houseknecht							Address 123 Tolgate Owings Mills																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC LYMPHOCTIC LEUKEMIA</u> <u>2041</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>2040</u> (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>VIRAL UPPER RESPIRATORY INFECTION</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 1968, to <u>12/19</u> , 1968, that (I) (we) last saw the deceased alive on <u>12/19</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Frederick J. Krawiec Jr MD</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>12/19/68</u>														
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE Dec. 21, 1968					23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park					23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland														
24. FUNERAL DIRECTOR <u>H. J. Echhardt</u>										ADDRESS Owings Mills, Md.					25a. REC'D BY REGISTRAR DATE DEC 23 1968					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (11-68)
30M REV. 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17388		CERTIFICATE OF DEATH						17399	
1. DECEASED-NAME (Type or print) Georgia				First E. Middle Ward Last		2a. DATE OF DEATH Dec. Month 20 Day 68 Year			2b. HOUR 10:30 MIN A
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 21, 1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS 73 DAYS	IF UNDER 24 HRS. HOURS 73 MIN.
7a. BIRTHPLACE (State or foreign country) Fairmount Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 244 Mineral Hill Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) house wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Oakland Road	
14. FATHER'S NAME First George Middle Ford Last				15. MOTHER'S MAIDEN NAME First Amelia J. Middle Dize Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NO		17. INFORMANT Address Mr. Walter E. Ward 3416 Parkington Ave. 15					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis, acute DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac arrest.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dec. 1 thru Dec. 20	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1968 , to Dec. 20, 1968 , that (I) (we) last saw the deceased alive on Dec. 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Howard E. Hall DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12/20/68					
22d. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.				22e. ADDRESS College Ave., Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 23, 68		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Park		23d. LOCATION (City or Town) Liberty Road (County) Baltimore Co. (State)			
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown				25a. REC'D BY REGISTRAR DEC 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

173889

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17400

1. DECEASED-NAME (Type or print) First Middle Last LEE JESSE WILDER			2a. DATE OF DEATH Month Day Year 12 10 68			2b. HOUR 3:45 A M					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 09/15/89		6. AGE (In years lost birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Gaither		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Gaither Rd.		
14. FATHER'S NAME First Middle Last William Wilde			15. MOTHER'S MAIDEN NAME First Middle Last Minerva Lamb								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 215-18-0363		17. INFORMANT Address Springfield State Hosp. Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart failure due to old myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days			
								mths or yr.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Assoc with cerebral arteriosclerosis with psychotic reaction</u> <u>Chronic Schizophrenia of psychotic reaction</u>											
19a. DATE OF OPERATION <u>12/10/68</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Chronic Schizophrenia of psychotic reaction</u>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/15/58</u> , 19 <u>68</u> , to <u>12/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/10/68</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harry W. Haight</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/10/68			
22d. PHYSICIAN'S NAME (Type) G. G. Sagisi						22e. ADDRESS Springfield State Hospital, Sykesv., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-12-68		23c. NAME OF CEMETERY OR CREMATORY Liberty Baptist			23d. LOCATION (City or Town) (County) (State) Sykesville Md.			
24. FUNERAL DIRECTOR Harry W. Haight						25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

100-100000

TO THE DIRECTOR OF THE BUREAU OF THE ARMY
FROM THE ADJUTANT GENERAL
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing military operations or administrative matters.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10-60)
30M REV. 11-58

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17390					17401					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last WILLARD F. WILSON					Month Day Year Dec. 24, 1968			9:20 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		Nov. 23, 1882		86 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Gist			Ross Nursing Home			Farmer-retired				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Carroll		Sykesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R. D. 3	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Greenbury Wilson			Frances O. Shipley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			None		Mrs. Elva M. Wilson Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 ASD, Arteriosclerosis Gen. DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis, Chronic DUE TO, OR AS A CONSEQUENCE OF (c) Brain Syndrome - Cardiac Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1960 +0 12-24-68		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 12-24, 1968, that (I) (we) last saw the deceased alive on 12-24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Howard E. Hall				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-24-68				
22d. PHYSICIAN'S NAME (Type) Howard E. Hall				22e. ADDRESS Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12/27/1968		Lakeview Memorial Gardens		Carroll Co., Md.				
24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
				DATE DEC 30 1968		J. Charles Judge				

1944

REPUBLIC OF CHINA

1944



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17391										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17402									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last Rose Rosine WINSHIP										Month Day Year Dec 21 1968										2:25A M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
F			W			July 28, 1874			94 YRS.																				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			U. S. A.						Carroll Md.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Sykesville 21784			Grand View Mansion			HW			own home																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland			—			Baltimore			YES			3641 Greenmount Avenue																	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																										
Christian Simond			Mary Bechkel																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																				
no			215-48-4669			Edward J. Winship			(Same)																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease										30 yrs																			
DUE TO, OR AS A CONSEQUENCE OF																													
(b) Arteriosclerotic Heart Disease										30+yrs																			
DUE TO, OR AS A CONSEQUENCE OF																													
(c) General Arteriosclerosis										30+yrs.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
420.0 Advanced general senile changes																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
			19																										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from 3/15/64 , 19__, to 12/21/68 , 19__, that (I) (we) last saw the deceased alive on 12/21/68 , 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			22c. DATE SIGNED																										
Wm. H. Lawson, Jr., M.D.			12/21/68																										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
Wm. H. Lawson, Jr., M.D.			Box 54, RD #2, Sykesville, Maryland 21784																										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
Burial			12/23/68			Druid Ridge			Pikesville, Balto. Co.																				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			Md.																				
H.W. Jenkins & Sons Co.			4905 York Rd. Balto. 12, Md.			DEC 24 1968			Charles Judge																				

17509

SECTION OF 17509

17509



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

17392				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17403			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
Margaret Antionette Wynn				December 22 1968				11:20a			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-12-94		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Balt. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3 25 Birkwood Place			
14. FATHER'S NAME First Middle Last Joseph V anbuskirk		15. MOTHER'S MAIDEN NAME First Middle Last Unknown Anna		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 207-01-6398D		17. INFORMANT Records Address Springfield State Hospital Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> 470x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 481x Chronic Brain Syndrome assoc. with senile brain disease with psychotic reaction											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9-5-1968, to 12-22-1968, that (I) (we) last saw the deceased alive on 12-22-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Renato N. Espina, M.D.				22c. DATE SIGNED 12/22/68							
22d. PHYSICIAN'S NAME (Type) Renato N. Espina, M. D.				22e. ADDRESS Springfield State Hospital Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-26-68		23c. NAME OF CEMETERY OR CREMATORY Cathedral		23d. LOCATION (City or Town) (County) (State) Scranton Pa					
24. FUNERAL DIRECTOR Frank H. Seitz				25a. REC'D BY REGISTRAR DATE DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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RECORDS OF THE

1940

DEC 31 1940

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) MARY LOUISE YEARLEY			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 12-18-68 19		2b. HOUR 11:20		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4-28-85	6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 12-18-68 Year 19		2d. HOUR 11:20		
7a. BIRTHPLACE (State or foreign country) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 701 Monroe Street	
14. FATHER'S NAME Solomon E. Yearley			First Middle Last			15. MOTHER'S MAIDEN NAME Melissa Jane Samuels				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 215-48-3075			17. INFORMANT Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4211 (b) Stenosis of aortic valve with left ventricular hypertrophy DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary edema PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS associated with cerebral arteriosclerosis, with psychotic reaction									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days or Wks.	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									22b. DATE SIGNED 12-19-68	
ACTUAL SIGNATURE W. Glenn Speicher			EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 12-19-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-21-68		23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Mont. Md			
24. FUNERAL DIRECTOR Robert A Pumphrey			25a. REC'D BY REGISTRAR DEC 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				

11504

MECHANICAL ENGINEER'S REPORT

NO. 11504

ANALYSIS OF WEAR

1. Introduction

2. Object of the Investigation

3. Description of the Machine

4. Results of the Investigation

5. Conclusions

6. Recommendations

7. Appendix

8. References

9. Notes

10. Summary

11. Acknowledgments

12. Bibliography

13. Index

14. Glossary

15. List of Figures

16. List of Tables

17. List of Plates

18. List of Appendices

19. List of References

8000 03 Jan 1958



17304

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17405

FOR STATE HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
JOHN LUTHER ZEPP					MATED		12	26	1968	4A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
MALE	WHITE	JULY 1910		58 YRS.	MONTHS DAYS		HOURS MIN.		Month 12 Day 26 Year 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
CARROLL CO. MD.		U.S.A.				CARROLL CO.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
WESTMINSTER		54 JOHN ST.			LABORER			LUMBER YARD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.		CARROLL		WESTMINSTER				54 JOHN ST.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
GEORGE W. ZEPP					LAURA Z.					131st
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO				GEORGE A. ZEPP		WESTMINSTER RD#6 MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>										<u>sudden</u>
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
7201										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Julius Chepko				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Julius Chepko				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12/27/68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		12/28/68		WESTMINSTER CEMETERY		WESTMINSTER MD.				
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J. S. Myers, Jr.		Westminster, Md.				DATE DEC 30 1968		J. Charles Judge		

17405

FEDERAL BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]
DATE: [illegible]
[illegible text follows]

[Large block of illegible text, likely a memorandum or report body]

12/10/68
DEC 10 1968
[illegible text]